Mental Health Service Needs of a Latino Population: A Community-Based Participatory Research Project

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Abstract:

Community-based participatory research bridges the gap between academic researchers and the real-life issues of communities and offers promise for addressing racial and ethnic disparities in mental health care. The purpose of this community-based participatory research was to identify factors that affect access, use, and perception of mental health services by a Latino population at individual, organizational, and community levels. Individual level factors included health beliefs about mental illness and care, suspicions of providers, financial concerns, and culturally determined gender roles. Organizational factors included problems with access to care related to cost, lack of bilingual providers, and culturally competent care; and community level factors included distance between resources and the need for services to be provided in community sites. Immigration status and acculturation were identified as factors at all levels.

Article:

Latinos in the U.S. receive fewer mental health services than other groups even though the prevalence of mental illness in Latinos is similar to that in other groups (Kessler et al., 1994; National Healthcare Disparities Report, 2005; Robins & Regier, 1991; U.S. Department of Health and Human Services, 2000; Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano, & Caraveo-Anduaga, 1998). The Institute of Medicine, Centers for Disease Control and Prevention, National Institute of Mental Health/NIH, the Department of Health and Human Services and Healthy People 2010, have all identified a need to address this disparity. The need is especially acute given the prediction that Latinos will constitute 24.4% of the U.S. population by 2050 (U.S. Census Bureau, 2004). The term Latinos is used to refer to all persons of Cuban, Mexican, Puerto Rican, South-or Central American, or other Spanish culture or origin. Latinos can be of any race. In fact, the federal government considers race and Latino origin to be separate and distinct concepts (Office of Minority Health, 2006).

North Carolina has the fastest growing Latino population in the United States (NC Institute of Medicine, 2003; U.S. Census Bureau, 2005). In 2005, Latinos made up 6.3% of the population in North Carolina, and in Guilford County, where this study was conducted, Latinos accounted for 5.4% of the population (U.S. Census Bureau, 2005).

Generational status, nativity status, ethnic subgroup (Mexican, Cuban, Puerto Rican, other Latino descent), age at migration, English language proficiency, and years in the U.S. all affect the prevalence of mental illnesses among Latinos (Alegria, Mulvaney-Day, Torres, Polo, Cao, & Carino, 2007). Those born in the U.S. have been found more likely to experience depressive disorders, anxiety disorders, and substance use disorders than those born in their native countries (Alegria et al., 2007). Third generation Latinos have been found to have higher rates of these psychiatric disorders than first-and second-generation Latinos (Alegria et al., 2007). Among Latinos, Puerto Ricans have been reported to have the highest prevalence rate of these disorders (39%), followed by Mexicans (28%), Cubans (28%), and those of other Latino descent (27%) (Alegria et al., 2007). Differences between the subgroups of Latinos mandate attention to the particular mental health needs of these subgroups.

Situational and socio-cultural issues also affect the mental health service needs of Latinos. Those with relatively low educational and economic status may experience more stress and thus greater susceptibility to mental illness (U.S. Census Bureau, 2004; U.S. Department of Health and Human Services, 1999). Discrimination and illegal immigration status also impinge on Latinos' mental health (Stuber, Galea, Ahern, Blaney, & Fuller, 2003). Discrimination contributes to poor self-assessed mental health (Stuber et al., 2003), while being undocumented can cause fear and anxiety due to limited resources, marginalization, isolation, stigmatization, and exploitability (Sullivan & Rehm, 2005).

Barriers to mental health care for Latinos include the lack of Spanish-speaking and Latino mental health care providers and a lack of health insurance by this population (Ruiz, 2005; U.S. Department of Health and Human Services, Office of the Surgeon General, 1999). Religious beliefs, acculturation, and beliefs about mental illness and treatment also have been posited as barriers (Bernal & Sāez-Santiago, 2006).

This article reports the mental health service needs of members of a North Carolina Latino community that were identified through a community-based participatory research (CBPR) approach. Specifically, this CBPR study examined individual, organizational, and community level factors affecting access, use, and perception of mental health services for a Latino population in Greensboro, North Carolina.

COMMUNITY-BASED PARTICIPATORY RESEARCH

Community-based participatory research, with its roots in action research, empowerment, critical theory, and constructivism, is not a method but “an orientation to research” (Minkler & Wallerstein, 2003, p. 4). Israel, Shultz, Parker, and Becker (1998) define CBPR as:

> a collaborative approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process. The partners contribute 'unique strengths and shared responsibilities' to enhance understanding of a given phenomenon and the social and cultural dynamics of the community, and integrate the knowledge gained with action to improve the health and wellbeing of community members.” (p. 177)

Community-based participatory research challenges “both positivist notions of knowledge and traditional top-down processes of academia” (Minkler, 2006, p. 29) and is particularly appropriate for culturally competent research (Meleis, 1996).

Community-based participatory research offers promise for addressing health care disparities in Latino communities (Kim, Flaskerud, Koniak-Griffin, & Dixon, 2005). White, Suchowierska, and Campbell (2004) suggest that the advantages of CBPR are “the development of more pertinent research questions, user-friendly instruments, acceptable interventions, thorough data analysis, and effective dissemination strategies” (p. S3). Community-based participatory research has been successfully conducted in mental health (Khanlou & Peter, 2005) and is consistent with the National Institutes of Health Roadmap Initiatives (Zerhouni, 2003), one of whose goals is to address previous failures in translating research findings to community practice by developing “new partnerships of research with organized patient communities, community-based health care providers, and academic researchers” (National Institute of Health, no date). Portillo, Villarruel, Siantz, Peragallo, Ruiz Calvillo, and Eribes (2001) recommend that research on Latinos should include Latinos as full participants in the process from study design, to implementation, analysis and dissemination.

SOCIAL ECOLOGICAL MODEL

The Social Ecological Model (SEM) is consistent with CBPR because it involves a community understanding of health, requires interdisciplinary approaches to interventions, and clarifies the complex relationships “among persons, groups, and their sociopolitical milieus” (Stokols, 1996, p. 283). The SEM provides an overarching framework for examining individual, organizational, and community factors in mental health services needs (Fleury & Lee, 2006; Stokols, 1996). Individual factors include psychosocial attributes (e.g., health beliefs and self-concept), educational level (e.g., skills and occupation), lifestyle characteristics (e.g., meal pattern, activity level, and alcohol and tobacco use); factors such as family, friends, and social support networks; and the norms, shared beliefs, and religion that provide social identity.

Organizational resources reflect the connection of community members with services and opportunities that facilitate risk reduction (Minkler & Wallerstein, 1997). Organizational structures and processes can be used to support behavioral change, serve an important role in health promotion activities, and are vital in the diffusion of health promotion programs (McLeroy et al., 1988; Stokols, 1996). Organizational level factors include funding, climate and personnel, sociopolitical sentiments, and policies.

Community level factors include the physical environment and all assets and resources within it as well as socio-cultural norms that influence individuals' values, beliefs, and attitudes (McLeroy et al., 1988). Community level resources, like individual and organizational level factors, can act as both enablers and barriers to access and use of mental health services by Latinos.

METHODS

Setting and Sample

Using a purposeful sampling design, individuals from the university-affiliated Center for New North Carolinians and the Center for Youth, Family, and Community Partnerships were contacted for a list of racially and ethnically diverse individuals who might be interested in

joining a CBPR team to study the mental health service needs of the local Latino community. The first author contacted these individuals, explained the purpose of the study, and solicited interest and participation.

The initial CBPR team included three community members—a private mental health care provider, a Latina lay health advisor, and a health advocate and family member of a mental health consumer. Before the first meeting, one group member (the Latina lay health advisor) recommended another person for the team—a woman who provided case management and referral services for Latina mothers and mothers-to-be, and she was asked to join the group. After the first meeting, the CBPR team expanded once again to include a Latino therapist from the local community mental health center, who was referred by one of the other team members. After the second meeting, two other persons were recommended for the team—a Latina woman who was the Assistant Center Director at Head Start, and the Latino mental health awareness campaign director for the local Mental Health Association.

Consistent with CBPR principles, community members and academic researchers were both participants and co-researchers (Jones & Wells, 2007). The study sample was the CBPR team, which was made up of seven community members, one public health educator, one doctoral student in nursing, two undergraduate nursing students, and the first author, who was principal investigator. The seven community members were a diverse group. Three were from countries other than the United States—Peru, Guatemala, and Mexico; two were men and five were women; six worked with the Latino community in their current jobs and most worked with families. The ages of the community members ranged from 24 to 53. Four community members worked in child and family development services, and the others worked in some area of medical or mental health care. The whole CBPR team (community members, academic researchers, and students) ranged in age from 21-53 (mean = 36.4) and included two men and ten women; three Latinos/Latinas, two Blacks/African Americans, one African, and six Caucasians.

Data Collection

Data were collected from October 2006 through February 2007. The CBPR team functioned as a focus group, and four two-hour focus groups were held over four months. Prior to the first focus group meeting, community members were asked to think about individual, organizational, and community level factors that affected access, use, and perception of mental health services for Latinos. The first author organized the focus groups, provided an overview of CBPR for the group, and guided the discussion during the first focus group. The question, "What are the issues with mental health care for Latinos in our community, for example, access, quality, availability, culturally appropriate services, etc.?" was used to open the discussion at the first focus group. Group members added other categories of concern, such as issues related to general health care. Group facilitation was later increasingly shared by group members with each successive group session. Verbatim transcripts were shared by the first author with all team members prior to each subsequent focus group. Focus group members provided clarification or corrections to the transcripts and used these transcripts to further their discussion of issues important to the Latino community. Community members were given lunch, a gift card, and a parking voucher at each focus group session as incentives for attendance.

Data Analysis

CBPR team meetings were audio-taped, transcribed, and then entered into the qualitative data analysis software program ATLAS.ti 5.0. Data were analyzed using qualitative description (Sandelowski, 1996, 2000), a low-inference method of analyzing and representing qualitative data that is particularly useful in studying vulnerable populations (Sullivan-Bolyai, Bova, & Harper, 2005). Preliminary findings included an initial problem list and possible solutions. These findings were reviewed and discussed with CBPR team members, and the findings were then refined and categorized according to the Social Ecological Model. Two themes—immigration and acculturation—were present at each level of the SEM. In the final analysis, immigration and acculturation were extracted and placed in a separate category entitled pervasive factors. All CBPR team members agreed on the final analysis.

FINDINGS

Mental health service needs were discussed by members of the community research team and appropriate solutions were proposed. These mental health service needs and proposed solutions are presented below at the individual, organization, and community levels of the Social Ecological Model.

Pervasive Factors

Two pervasive factors identified at each level of the SEM were immigration and acculturation. Undocumented immigration status gave rise to feelings of fear and anxiety, which influenced how individuals saw themselves, interacted with others in the community, and accessed resources. One group member described how immigration status affected her Latina clients: They're just tense all of the time. I think like 99.9% of my clients are undocumented. So, now they're—I mean with all the immigration stuff going on, they're just tense all the time because they think they can be deported any minute. "If the police catch me, I'm going to be deported." It's a really big fear. So they're living in this constant fear of being found out, which is also one of the reasons they don't get out and why they're so isolated; it is because they're not documented.

Some Latinos, especially those without health insurance, believed that there were no mental health services for them. When they needed mental health care, they would say, "I don't have papers, I don't have insurance, they're going to catch me … what am I going to do?" This uncertainty about care and the precariousness of their immigration status prevented many from seeking mental or physical health care.

Documentation status also significantly contributed to self-identity. One participant described Latinos as people who are constantly being watched, discriminated against, marginalized, detained, prosecuted, and deported. This self-identity limits the amount of interaction Latinos are willing to have with others, the places they go, and the resources they believe they have access to.

Group discussion of acculturation focused primarily on language barriers. Group members said that children were often bilingual, while their parents were not. Since communication is a prerequisite for learning about and adopting a host nation's culture, children were more likely to assimilate to U.S. culture than parents. As a result, parents found acculturation to be a major threat for Latino youth. Language proficiency, however, also impacted parents. Inability to speak

English was seen as a barrier to job attainment and ability to access health education messages and mental health services.

Individual Level

Beliefs about the causes of mental illness, suspicions of providers, and the perceptions on who can and cannot be treated for mental health conditions were identified as major barriers to access for Latinos. Mental illnesses were often thought to be caused by curses and other malevolence. One community member found this especially challenging when trying to conduct a mental health family history. Responses such as, "They put a curse on him, and he's been in bed ever since, for 17 years," were not uncommon when Latinos were asked about a particular family member.

The Latino community's understanding of mental illness differed from that of the medical establishment. Often, somatic descriptions of illness were given that matched the symptoms of depression and other mental illnesses, but very few described their suffering as mental illness. For example, one community member said,

People can be depressed, or not be eating well, not be sleeping well, feeling nervous or they get headaches, they get stomachaches, but they will never say, "I'm depressed. I miss my country. I want to go home. I don't like it here." Rather, they will acquiesce to their situation and remain silent about their feelings.

As this participant noted, these symptoms are not called mental illness. "That's not a term that's part of the language they speak. So, we have to look for—we need to help them associate what they describe as mental illness in our language."

Team members noted that early in the client-practitioner relationship, when trust and rapport had not yet been established, Latinos were often suspicious of the practitioner and reluctant to disclose significant complaints or problems. As one non-Latina research team participant said, "I meet with somebody; they're always kind of guarded because they're wondering 'What is this American doing in my house? And how is it they speak Spanish? And what's going on?'"
The cost of mental health care also was mentioned as a significant limiting factor for the Latino community. Latino families in this community are often in a perpetual cycle of poverty: low education and low skills dictate the type of work and number of hours they must work, influencing the amount of time they spend with family members. During a discussion on financing mental health treatment, one community member said:

I wanted to refer this client to a therapist … the Spanish-speaking therapist charges like $100 and something an hour … even if she could give a reduction, they're still too expensive. The point is that these people are not making a lot of money. Like $20,000 a year or something … it's just not enough … Because like all these studies are saying like the majority are from rural areas, a fifth-grade education and very low socioeconomic skills. Even talking mental health, "Talk to this person about your problems" is such a foreign concept, you know? Plus paying for it and all.
Personal histories and experiences, including traumatic experiences while crossing the border, domestic violence and/or sexual abuse, and nostalgia for the homeland were common stressors. Fractured social support networks due to isolation and fear also placed a burden on families,

which was exacerbated by racism and fears of deportation. Families were forced to be self-reliant and independent, with little or no opportunity to report abuse or violence, or get advice, services, or help for emotional distress. Depression, anxiety, substance abuse, and symptoms of post-traumatic stress disorder were not uncommon.

Culturally determined gender roles also influenced understandings of mental illnesses, and access, use, and perceptions of mental health services. Community group members identified men as the dominant figures in families. The men were generally stoic and reticent about feelings and emotions, and wanted little to do with homemaking and child rearing. They were viewed as breadwinners, who were responsible for attaining basic needs not only for their immediate families, but also their extended families, who might be still in their country of origin.

Community members noted that men's reluctance to talk about problems, compounded with the stress of being in a new country, lack of social support, and the need to bond to other men, could lead to alcoholism, substance abuse, and violent behaviors. Community members said that few men, however, would seek professional assistance for these problems.

Adolescents, especially those who experienced trauma while immigrating to the U.S., were identified as the most vulnerable group, who were often acting out their internal emotional struggles. They felt misunderstood, and were searching for acceptance and trying to form their own identity, but this was difficult with continued acculturation pressures. Acting out included risky behaviors that could lead to teen pregnancy, gang involvement, and dropping out of school. Group members summarized it this way,

These very adults we're talking about now are going to be replaced by these adolescents. What can we put into place to help the adolescents so that we don't relive this with them as adults? Hispanic adolescents are going to need help.

Although more Latina women were working outside the home than in earlier years, most were still expected to stay at home and be entirely responsible for homemaking and parenting. In public, women were expected to be respectful and submissive to their husbands; however, women also were identified as persons who could influence the family on mental health issues. Physical and sexual violence was real but underreported. Some community members described women's role and consequences:

She can't feel bad because she's got kids to take care of. She's got a husband to take care of. She's got a house to clean. She's got the food to cook. You know, she doesn't have time to get—she's mentally overwhelmed and doesn't have time to deal with it. They can live in an apartment complex with like 200 or 300 other people, but they still don't really—they don't get out. You know, like, all of us, we go to Barnes and Noble. We go to Borders or we go somewhere to get coffee. They just—they don't do that … Because the husbands are so, "Like I have to work. I have to work to send money back home. I have to work all the time." And the mom is at home with the kids going crazy. So she never leaves. She's in the house. This one had an apartment with three kids all day. And of course, she's going crazy. But she'll never say it.

Thus, isolation, overwhelming home and child care responsibilities, and abuse all contributed to women's mental distress, yet few women sought mental health services because it required their husband's permission or at least acknowledgment to take time away from the home.

Organizational Level

The sentiments expressed by one group member captured a formidable barrier to mental health services for the Latino community:

Access, I think, is an issue as well … because access and funding, you know, go so hand-in-hand, especially for undocumented immigrants that don't have access to Medicaid or state dollars … [the] county commissioners are saying, "We are not going to spend money on people that are not legal." But it really slaps in the face of what the work is, that has to be done. Because once again, the child is not going to be any less ill. They're not going to act out any less at school … So you have, like myself, a private provider who doesn't have county dollars or state dollars or even grant dollars then for a for-profit to provide services for lesser fees or no charge. There are only two or three places in Greensboro that work on a sliding scale.

Community members said organizations needed governmental support to implement more sliding-scale programs for Latinos. However, with anti-immigration sentiments and rhetoric high, organizations were unable to meet the mental health service needs of the Latino community.

Governmental policies, such as the North Carolina Mental Health Reform, have decentralized care, further limiting access points and stifling funding for organizations. Policies such as this have created a vacuum in care, leaving the Latino community without adequate mental health services. Mental health reform also has created other hurdles that the Latino community must go through to get mental health care. Community group members described it this way:

If you need a therapist, you must call a 1-800 number—the Access line. "Access" will screen, triage, and refer over the phone. A list of providers is then given to the caller, and depending on the need, an intake is scheduled. Through intake, the decision is whether the individual needs medication management. A psychiatrist or in-house nurse can be seen to obtain medication. If medication management is not needed, referrals are made to community providers for outpatient therapy. However, these services are not available to the Spanish-speaking community. The Access line is in English only.

Community members informed us that very few providers were bilingual. So, "If you get a Spanish-speaking person in, you are really limited as to who you can refer them to."

For those Latinos who did seek help and were able to manage the system, other barriers existed. Community group members noted a lack of client-centered care processes and care providers. Community members also discussed issues such as cultural competency and sensitivity. Providers with good interpersonal skills and a client-centered approach were considered by the group to be more successful in working with Latinos. Since there was usually client-practitioner discordance in race/ethnicity and culture, the first interaction was critical for establishing rapport. The group suggested finding a commonality with the client by talking about children, food, or

asking about the individual's interests. The group also noted that at times, clients might ask questions that had nothing to do with the topic at hand, such as, "What bank should I use?" Providers should not miss this opportunity, since for Latinos, this is part of the engaging process. It is okay to say, "I don't know, but I can find out for you" or "perhaps I can find a referral for you." Doing these things "gets you in the door," allows for trust to be built, and enables clients to feel more comfortable. As one community group member said, "People will respond, crossing those ethnicity boundaries that we artificially created … they really do respond to you, if they know you really care about them." Community members, however, agreed that time constraints and logistics severely limited opportunities to get to know clients.

Group members also found that health education materials and referral lists inadequately served the Latino community because many were not in Spanish, did not contain culturally adapted content, and used complicated language.

Community Level

In Guilford County, community resources and family and friends are often far apart. For undocumented immigrants, transportation is an issue. Driver licensing laws which require proof of documentation prevent many from driving, further isolating Latinos and limiting their access to mental health services. Even services that are available do not work on an affordable sliding scale fee structure. Churches, schools, community centers, and public libraries were identified as invaluable assets for the Latino community, since these were among the few institutions where Latinos felt comfortable to congregate and socialize without fear of marginalization, persecution, or deportation. Some of these institutions offer educational, physical, and mental health services for the community. The community research team thought that these arenas could serve as future access points for mental health education, community empowerment, and capacity building programs.

One of the greatest assets for the Latino community is its own people. As this CBPR group demonstrated, community members understand their own problems. Moreover, communities provide support and information to newcomers on issues ranging from where to live, bank, and shop to how to access medical and mental health services. One CBPR group member summarized the importance of community through churches and other organizations:

Those people live here. They're not going any where. It's like informal support. You know, the mental health system is a formal system. And informal supports and informal systems, you know, will work well. You know, churches, [and] community centers.

Extended family members in the community sometimes, however, exerted a negative influence on the mental health practices of Latinos. Mental illnesses were often perceived as "shame brought onto the family." If mental illnesses were present in the family, few were willing to talk about them because of the stigma. Consultations with health care providers about these matters also were taboo. The group told a story about an adolescent who could not get mental health services because the community felt that his immigration status would prevent care. It appears that if the need of one jeopardizes the survival needs of others, then the person's individual needs may be sacrificed.

DISCUSSION AND IMPLICATIONS

This CBPR study yielded substantial information about individual, organizational, and community socio-cultural factors affecting access, use and perception of mental health services for Latinos. The CBPR process was successful in connecting academic researchers with the real-life issues Latinos face when interacting with the mental health system and in providing information on the specific needs and concerns faced by this Latino community in regard to mental health services.

Participants noted that many Latinos expressed symptoms of mental illness or distress somatically. Somatization, common in many ethnocultural groups, including Latinos, has different meanings for different individuals—it can serve as a means of expression of disease, an indication of psychopathology, a symbol of intrapsychic conflict, a culturally coded expression of distress, or a means of expressing social discontent (Kirmayer & Young, 1996). Gaining an understanding of the meaning of this phenomenon for Latinos through the use of CBPR can lead to more accurate diagnoses and appropriate treatments.

Participants reported that before trust and rapport are established in a client-practitioner relationship, Latinos are often suspicious of the provider and reluctant to disclose complaints or problems. The trust and rapport needed for a therapeutic relationship can be established through understanding and incorporation of specific cultural constructs. Since many Latinos are family (familismo) and relationship (personalismo) oriented, incorporation of these constructs can help Latino clients feel more comfortable in disclosing problems and concerns (Añez, Paris, Bedregal, Davidson, & Grilo, 2005). Recognizing and including the family in the client's care and relating to clients in a personal manner can help clients feel that the professional has a personal concern for their well-being. Through the use of CBPR, academicians can learn to appreciate the importance of these and other cultural constructs in mental health care delivery, improve the delivery of culturally competent mental health care, and reduce mental health disparities.

Lack of adequate income and lack of health insurance were described by community participants as major barriers to Latinos accessing mental health care; these issues also have been noted by Ruiz (2002, 2005). In 2002, 32.4% of all Latinos were without insurance while 42.8% of Latinos living in poverty had no health insurance (U.S. Census Bureau, 2003). While having insurance does not guarantee access to mental health care or even quality care, not having insurance usually guarantees no care. Latinos who are uninsured are less likely to have a regular source of care, more likely to postpone seeking needed care because of cost, and more likely to not receive needed care. They are less likely to follow through with recommended treatments and may not fill needed prescriptions (Kaiser Commission on Medicaid and the Uninsured, 2006). Expansion of governmental policies, such as Medicaid, and financial support to augment programs offering sliding-scale fee schedules for mental health services for Latinos are needed. Participants opined that expansion of programs such as these would increase access to needed mental health care for Latinos in the study area.

The language barrier also was identified as a factor in the use of mental health services by Latinos. The most effective means of building relationships with clients is to have the same culture and speak the same language. Often, however, this is impossible and interpreters and

cultural brokers are required. Many members of the CBPR team have served in these roles, yet they all agreed that these were not ideal and often were awkward for all parties involved. For example, many practitioners made the mistake of focusing their attention on the interpreter, rather than the client. Clients therefore began to trust interpreters not practitioners, and relationships were never established between client and provider. Interpreters and culturally appropriate health education materials and resources often were used improperly. The adoption of the National Standards for Culturally and Linguistically Appropriate Services for Health Care (U.S. Office of Minority Health, 2001) would improve the quality of care. These standards include mandates for organizations to provide linguistically appropriate services such as interpreters and culturally and linguistically appropriate educational materials and signage (U.S. Office of Minority Health, 2001). Incorporation of these standards by mental health care providers would increase access, satisfaction, and maintenance of needed care.

Participants identified Latino adolescents as a particularly vulnerable group because of their risky behaviors. Acculturation pressures have been found to contribute to risky behaviors such as smoking and alcohol and drug use. Further, Latino adolescents with high degrees of acculturation engage in more risky behaviors as they try to fit in and adopt behaviors of American adolescents. They also engage in more risky sexual behaviors, putting them at risk for unplanned pregnancies and sexually transmitted infections (Bartlett, Buck, & Shattell, in press; Villarruel & Rodriquez, 2003). Additionally, acts of racism against Latino adolescents have been associated with violence, sexual abuse, drug use, and worry about doing dangerous things (Surko, Ciro, Blackwood, Nembhard, & Peake, 2005). Discussion of this concern between academicians and Latino mental health providers through CBPR can lead to the development of collaborative strategies for intervening with this population.

Many Latina women suffer from the effects of domestic abuse, as noted by these participants. According to national data, 55% of Latinas report violence experienced over their lifetime (National Women's Law Center and Oregon Health & Science University, 2004). Reasons for this violence include stressors related to immigration, challenges of acculturation, economic pressures, legal and language challenges, low-income status, and alcohol or drug abuse (Murdaugh, Hunt, Sowell, & Santana, 2004). Because of illegal immigration status, lack of resources, and the need for the husband's permission to seek care, Latinas are unable to receive assistance for domestic violence. Encouragement to report domestic abuse accompanied with assurance of safety provisions can be promoted through CBPR.

It can be very difficult to penetrate the Latino community. One group member put it this way: Latino people are very relational … everything we do is based on relationships. And it's very difficult to establish; you almost have to earn the right to have a relationship. You have to earn that respect. You have to spend the time to find out about the family and about what they like and dislike.

According to participants, researchers and practitioners alike will need to invest more time in understanding to obtain buy-in from the community for solving problems.

Because of the many barriers to addressing mental health treatment in the Latino community, the CBPR group concluded that a holistic community-based intervention was needed. This approach

would enable researchers and practitioners to get to know the Latino community in their "natural environment," and allow Latino families to feel more comfortable, respected and cared about. In the words of one community member:

I think the community-based model works very well with the nature of the culture for Latinos in general. Latinos are hospitable people. They like having people in their homes. They feel important. They feel respected. Hospitality is a very high value in the Latino culture. It's about the human contact. Especially if they're getting help. They're getting assistance. Like I said it's more global. It's more of a community-based, relationship-based success I believe.

As a result of this pilot study, we identified several areas in which more research needs to be done. These areas include the effect of a translator on establishing rapport, benefits of peer or lay health advisors in the community, effect of documentation status and acculturation on immigrant populations, and the differences in health beliefs among the many Latino populations. Findings from such research can be used to design multilevel interventions to address racial and ethnic disparities in mental health care in this community.

This study shows that a CBPR approach can be used to identify and formulate ways to address factors at individual, organizational, and community levels that affect mental health services access and use. Community participation, analysis, and proposed solutions for the problems faced by the community are vital components of CBPR. Knowledge gained from CBPR can promote awareness and advocacy initiatives, act as a catalyst for organizational change, and potentially impact local, state, and federal mental health policies.

The members of this CBPR team were providers and advocates. A limitation of the study is that our findings are based on the perspectives of community members who were providing community mental health care or other support services as Latina lay health advisors, consumer/family advocates, and child development (Head Start) providers in the community. Representatives from other areas of the community such as faith-based groups or churches, consumers of mental health services, and persons struggling with mental illness (without the benefit of services) could have expanded our findings.

The work of this CBPR team is not complete. After the study reported here, community members suggested that a second study should focus on Latina women because women are more amenable to addressing mental health issues, and a focus on depression because this is a common problem. Also, because women are the center of families and the Latino community, community members thought that such a study would be a way to serve the entire family. Based on these findings and on the interest of the community members, the CBPR group planned and is currently conducting a study of Latina women to identify their mental health service needs. Three focus groups, in Spanish, facilitated by Spanish-speaking CBPR group members, will be conducted with adult Latinas. Community members are all full participants in the proposed research. They completed human subjects training, chose the study population and focus, designed the focus group interview guide and recruitment flyers, and will facilitate the focus groups and actively participate in data analysis and dissemination. One community member is also a co-author on this article (all CBPR members were invited to participate in the dissemination efforts). Findings from the next study on Latina mental health will be used to

develop and pilot test an intervention. Concurrently, the CBPR team is planning a federal grant proposal to support an extended, formalized, and sustainable Coalition for Latino Mental Health.

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